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BARBITURATES

FRIEND OR FOE?

MEDICAL

BARBITURATES—FRIEND OR FOE?

by S. J. HOLMES, M.D., D.Psych.

Dr. Holmes has had considerable experience with drug addiction, serving as consultant to the Drug Addiction Clinic at Mimico Reformatory from its inception in 1957 until June, 1962. He will direct the narcotic addiction unit presently being organized in Toronto by the Addiction Research Foundation of Ontario.

THE BARBITURATE problem has been described by Isbell and his group from Lexington, Kentucky, as more devastating than opiate addiction. Opiates cause much less impairment of mental ability and emotional control and produce no motor inco-ordination. Furthermore, such impairment as does occur becomes less as tolerance to morphine develops, and there is not the wide variation in response to the daily dose. In addition, the withdrawal from morphine is not as dangerous as the withdrawal from barbiturates.

The production of consumption of barbiturates since the introduction of the drug in 1903 in its various forms and under its various trade names, has shown a progressive increase. In Canada, all barbiturates are imported, and imports have been increasing by approximately one ton a year since 1952. In 1951, approximately 24,855 pounds of barbiturates were imported into Canada; this figure increased to 36,175 pounds in 1952. In 1962, imports of barbiturates totalled 57,450 pounds. In comparison, there was an increase of prescribed barbiturates in Great Britain from 90,000 pounds in 1951 to 162,000 pounds in 1959. About seven per cent of all prescriptions issued in Great Britain were for barbiturates and about two and a half per cent were for stimulants.

Three Groups of Barbiturates

The Division of Narcotic Control, Department of National Health and Welfare of Canada, divides barbiturates into three groups: short-, medium-, and long-acting in their effects. In the short-acting group are hexobarbital (Evipal), pentobarbital (Nembutal), and secobarbital (Seconal). In 1962, imports of these short-acting drugs totalled approximately 15,114 pounds in straight form, and 70 pounds in the form of preparations. In the intermediate-acting group are amobarbital (Amytal) and butabarbital (Butisol); imports of these drugs in 1962 totalled 18,854 pounds in straight form and 473 pounds in the form of preparations. Barbital and phenobarbital fall within the long-acting group; imports of these drugs in 1962 totalled 22,105 pounds in straight form, and 833 pounds in the form of preparations.

Difficult to Estimate Addiction Rate

This increase in barbiturate production has come during a period when there has been an almost astronomical increase in the production and consumption of tranquilizers. The significance of these figures cannot as yet be fully appreciated in terms of dependence and addiction. However, surveys to date of the distribution of barbiturates as reported by the Division of Narcotic Control, Department of

National Health and Welfare, which began to take these preparations under scrutiny in September, 1961, would seem to indicate that there is quite a sizeable drug problem in our population relative to this chemical.

However, the actual incidence of chronic barbiturate addiction is as yet difficult to estimate since it is not a reportable condition. Also, it is so often associated with alcohol or with other drug addiction that it is not recognized as such by physicians, or it is misdiagnosed for an organic nervous system disease. Possibly one of the reasons for the emphasis being placed on other conditions than barbiturates is the fact that until recently it was commonly held that these drugs did not produce dependence and so could be used safely to palliate the symptoms of various other types of illness. This was partially produced by the advertising pressure of the drug houses who have finally, since 1946, put "May Be Habit Forming" on their labels. Inadequate control of distribution was remedied in 1953 by more stringent legislation aimed at the loose handling of the drug by physicians and druggists and its availability to pedlars. Now barbiturates alone, or in combination to a dose of 1/32 grains, require prescription. Further to this, in September 1961, barbiturates along with amphetamines came under control as outlined in the Food and Drug Act, Part III.

There is evidence, however, from the German literature that barbiturate addiction was recognized prior to 1939, as there are articles describing convulsions and/or a psychosis resembling the delirium tremens of alcohol following withdrawal of barbiturates from addicted persons. During this period, much attention was paid in the American and English literature to the effects of barbiturate intoxication to the exclusion of recognizing chronic addiction problems.

Suicides or Accidents?

Between 1922 and 1945, the increase in fatalities in the United States with barbiturates was 300 per cent and was exceeded only by carbon monoxide poisoning. Barbiturates are also the most common agents used in suicidal attempts and, as many people have pointed out, many of the suicides are not intentional but are the result of impaired judgment and memory.

Thus, individuals who are acutely or chronically intoxicated with the drug take more and more and finally kill themselves. In this way also the alcoholic, who after a night of drinking and having attained a high blood alcohol level, may take or be given by a physician or friend, some barbiturates which could potentially be fatal, since these two chemicals seem to have a synergistic action.

Such cases of barbiturate coma are medical emergencies and should be rushed to the nearest general hospital. Here a poison control centre, if available, will take the necessary steps to counteract the severe respiratory and circulatory depression. In general, the approach consists of lavage with magnesium sulphate, endotracheal intubation with oxygen therapy by pressure in the bag or continuous flow, intravenous fluids, non-convulsive electrical stimulation, and chemical stimulation with such chemicals as megimide, picrotoxin and other pressor drugs.

Statistics released by the Dominion Bureau of Statistics for Canada show that in 1960, barbiturates caused 56 of 212 accidental deaths while in 1961, the rate was 64 of 236 accidental deaths. In the suicide groups, although the exact figure relative to barbiturates is not known, it is reported that in

1960, poisoning by analgesic and soporific substances caused 118 out of 1,350 suicides, and in 1961, the figures was 140 out of 1,366 suicides. A report from the coroner's office in Vancouver revealed that there were 22 deaths attributable to barbiturates in 1960, 33 in 1961, and 31 during the first six months of 1962. In Toronto, the coroner's office does not differentiate the cause of death other than "Poisoning by analgesics and soporifics" and the incidence of barbiturates is implied as high. In Toronto there were in 1959—42 deaths from analgesics or soporifics, of which 13 were male and 29 were female; in 1960—39 deaths, of which 16 were male and 23 were female; and 1961—55 deaths, of which 22 were male and 33 were female. There is a need for some control in the amounts of barbiturates that are prescribed to a new patient to reduce the possibility of the initial prescription being a lethal dose, until both the patient and the condition are better known to the doctor. This should be done, in my opinion, even at the risk of complaint by the patient of increased cost or frequency of need for refill of the prescription as being in the long run in the best interests of the safety and welfare of the patient.

Barbiturates and Alcohol—A Parallel

Most of those who use the drug for the purpose of chronic intoxication prefer the short-acting potent types, such as Seconal, tuinal, Amytal and Nembutal, rather than the longer-acting drugs, such as phenobarbital and barbitol. The drugs are usually taken orally, although it is reported that some of the narcotic addicts will inject them intravenously. The use of barbiturates parallels the pattern of the use of alcohol. They may be taken for a one night stand, or for short bouts, or over long periods of time, for months and years. Until recently, they could be obtained without a prescription, or on the strength of an old prescription, without the doctor ever being informed. This occurred early in my experience when an original prescription for a woman suffering from symptoms related to anxiety state—for 24 capsules—was prolonged for approximately two years without my knowledge, and during this period she went through a normal gestation being delivered of a normal child before I saw her again suffering from chronic intoxication, at which time she was on a dose of 18 to 20 grains of tuinal per day.

Here again, the need for a written prescription each time, rather than a verbal order might be better preventive medicine. Also, the Narcotic Control Division may be able to report the type of patient who shops from one doctor to another to the doctors concerned for their information and action.

Tolerance Varies

The amount of daily intake, as with alcohol, to maintain a state of chronic intoxication varies from patient to patient once the upper limits of tolerance have been reached. The effects of the same dose vary markedly in the same person from day to day. Doses which one day will produce marked intoxication and even coma will another day produce only mild signs of intoxication. This variation in effect, as with alcohol, may be produced by as little as one and a half grains and is partially related to the food intake. The effects of the drug on the mood of the addict are also variable and appear to be related to the prevailing mood of the individual. One day he may be garrulous and happy, on another downcast and weeping. As with alcohol, barbiturates seem to

accentuate the basic personality pattern in the individual. Extroverted individuals are usually euphoric, talkative and humorous; shy persons more withdrawn; schizoid and cyclothymic personalities show greater mood swings.

Persons addicted to barbiturates develop a partial tolerance to the sedative and hypnotic effects of the drug. In fact, those who use these drugs sleep only an hour or two more per day than they do normally. It is probable that no tolerance can be developed to the lethal effect of these drugs, so that taking a large dose by the disturbed addict may be just as likely to cause death as is ingestion of the same dose by a person who is not addicted to these drugs. Tolerance to one type of barbiturate in animal experiments conferred partial cross tolerance to others.

There would appear to be, as reported by Jacobsen, a cross-tolerance phenomenon in people with regard to alcohol, barbiturates, meprobamate (Equanil and Miltown), and chlordiazepoxide (Librium). Another factor which influenced the control of both barbiturates and amphetamines is the use of these drugs by the same person so that one will counteract the effect of the other. In other words, a person who was pepped up or high on amphetamine would use barbiturates to sleep and the person who was drowsy or hung-over with barbiturates would use amphetamine to liven up. In this way, tolerance to very large doses of each could develop.

Predisposing Factors in Addiction

From the point of view of etiology, as with narcotics and alcohol addiction, personality disorders appear to be the most important predisposing cause of addiction to barbiturates. The psychoneurotic group, most commonly obsessive compulsives with a high degree of anxiety, are often introduced to the drug by physicians in order to induce sleep. The need for this drug may become more prolonged in many of these people who then develop a psychological dependence with a gradual increase in dosage until intoxication may be reached. One of the procedures in hospital practice—which has been common to my experience as well as the experience of others with whom I have discussed it—is the problem of the nightly requests of the nurses on the ward for a nightly order of laxative and sedative. This is a ritual that in his ignorance, and with a desire to please, the intern signs his name to and which results in potentially an indifferent attitude toward the use of barbiturates as well as forming an unnecessary association in the patient's mind relating these drugs to sleep ability.

The psychopathic personality uses the drug to obtain intoxication rather than sleep, and such a person tends to elevate the dose rapidly from the onset. In both these groups, we have those who use the drug either along with alcohol or narcotics when these may not be available, or to reinforce the effects of these other drugs. Addictive use of barbiturates by opiate addicts has become quite common; about 20 per cent of white opiate addicts are also barbiturate users. Another source of introduction that I have encountered has been in the alcoholic who has been given the drug during the withdrawal phase from alcohol and who has found he experienced a similar effect but now with a substance that did not smell that he could hide better and which did not interfere with his appetite, and so he could take the drug for a longer period of time. A similar relationship appears to be growing in this way relative to the use of certain tranquilizers.

The Clinical Picture

The clinical picture of chronic barbiturate intoxication is identical with that of moderately acute intoxication. The phenomena observed are predominantly due to the effect of the drug on the central nervous system and may be divided into mental and neurological signs. The mental signs of barbiturate intoxication include impairment of intellectual functioning, confusion, poor judgment, depression, melancholia and psychic regression.

Individuals addicted to this drug neglect their appearance, become unkempt and dirty, unshaven and wear soiled clothes. They have difficulty in performing simple tasks and in performing simple psychological tests. They are irritable, morose and quarrelsome and very unreasonable to any aproach on the part of the physician. Their judgment is so impaired that even when they are so intoxicated that they can't walk, they will continue to take the drug. This condition has been labelled automatism and may lead to death. They are careless with cigarettes and constitute a very real fire hazard. They become so depressed that suicide may be a real possibility. They regress to an infantile level—have to be waited on, fed, nursed and will soil the bed and lie in the filth. Emotional control is impaired and they are likely to fight over minor incidents or fancied insults. Some addicts become hostile and develop mild paranoid ideas. While taking the drug, the addict is usually correctly orientated in time, place, and person, and seldom has hallucinations or delirium. True toxic psychoses are rare while on the drug, unless superimposed on some other form of chronic mental illness.

The neurological symptoms may be quite marked and may be suggestive of organic disease such as Parkinsonism, multiple sclerosis, cerebellar tumor, and general paresis. The signs observed include ataxia in gait and station, dysarthria, nystagmus, adiadokokinesis, hypotonia, tremor, decrease in abdominal reflexes, occasional ankle clonus and Babinski sign. There are no sensory changes or deep reflex changes unless there are superimposed nutritional changes which are rare since barbiturate addicts, who take no other drug, usually maintain a good state of nutrition as compared with the alcoholic.

Effects of Withdrawal

Prior to 1949, the majority of the papers that occurred in the American and English literature stated that no abstinence symptoms occurred in withdrawal of these drugs. The German investigations have been more astute and have recognized since 1912 that convulsions and delirium may follow abrupt withdrawal of barbiturates from the chronic intoxicated patient and have recognized the similarity between the abstinence syndrome and the delirium tremens of alcohol. After 1940, there appeared some articles in the American literature reporting abstinence symptoms produced experimentally in animals and clinically in man.

In 1950, Isbell and his group conducted an experiment in which a group of five morphine addicts were withdrawn from the narcotic for a period of time and then exposed to barbiturates for periods ranging from 92 to 144 days. Following withdrawal, some of these patients developed convulsions, some presented a picture of delirium, and some exhibited both. These symptoms did not occur while they were taking the drug and complete recovery occurred without evidence of damage that could be deduced by clinical or psychometric evaluation.

The Physician's Role

In the withdrawal phase, the physician should orient his activities toward the primary object at hand, namely withdrawal of drugs. His role should be sympathetic and understanding but firm, and discussion of problems likely to arouse intense emotional reactions should be avoided. On the other hand he should be alert to the development of severe depressive reactions because of the danger of suicide, especially immediately after all drugs have been withdrawn. Fortunately, such disasters have occurred very infrequently, but milder depressions of temporary duration are not uncommon. Physicians who are confident of their own skill in the management of drug withdrawal generally have much less difficulty with patients who are quick to size up the therapist and to seize control of the situation if indecision, anxiety or hostility are deployed toward them.

When the drug is immediately withdrawn, the patients appear to improve for the first 12 to 16 hours. Their thinking and mental status become clearer and their neurological signs disappear. As the signs of intoxication clear, the patients become apprehensive and so weak they can hardly stand. Fasciculation of various muscle groups, and coarse tremor of hands and face, may be seen. The deep reflexes are hyperactive and slight stimuli may produce excessive muscular responses. The patients cannot sleep, are nauseated, have abdominal cramps, may have diarrhoea and may vomit frequently. A weight loss may occur up to 12 pounds during the first 36 hours due to loss of body fluids and decreased fluid intake.

Concomitantly, there is an elevation of non-protein nitrogen, hypoglycaemia and hemoconcentration due possibly to dehydration. Changes occur in pulse and blood pressure and are marked when the patient stands. There are no clinical electrocardiagraph evidences of myocardial damage. Weakness, tremor and anxiety continue. About 10 per cent of the patients will have one or more grand mal convulsions between the 16th hour and the third day but usually about the 30th hour. These may occur several times. The EEG will show paroxysmal bursts of high voltage slow waves before the convulsions occur, and may be present after the convulsion is past; after the abstinence syndrome, the EEG will return to normal.

Some patients show psychotic disturbances often heralded by 24 to 48 hours of insomnia. These patients will experience both visual and auditory hallucinations with the former predominating. The hallucinations resemble those seen in patients with delirium tremens. The emotional reaction will be governed by the basic personality of the patient. Some patients recover within three or four days while others may require two to three months. Improvement usually begins with the return of the ability to sleep.

Mechanisms in the Abstinence Syndrome

At the present time, little is known concerning the mechanisms that are involved in the genesis of the barbiturate abstinence symptoms. The fact that convulsions occur, after the withdrawal of drugs with anti-convulsant properties, suggests again that counter-adaptions may develop at cortical or subcortical cellular levels during chronic barbiturate intoxication. On the other hand, alternative hypotheses can be advanced, based upon recent evidence, that barbiturates exert selective depressant actions on the brainstem reticular activating system, and the role of this on the diffuse thalamic projection system in the genesis of seizures is an interesting speculation. Unfortunately, practically no studies have been made in the neurophysiological changes that occur during recovery from the initial depressant effects of barbiturates. Carrying out of such investigations would entail technical difficulties of formidable proportions, but they appear to be necessary for the ultimate resolution of the problem.

The symptoms of the abstinence syndrome vary considerably from patient to patient. Some individuals escape without experiencing more than weakness and anxiety. Others have convulsions but not a psychosis and others have both.

Two Phases of Treatment

The treatment of barbiturate addiction, like that of alcohol or narcotic addiction, can be divided into two phases—withdrawal of the drug and subsequent rehabilitation and psychotherapeutic treatment. Abrupt withdrawal has been considered by Isbell to be absolutely contra-indicated. However, in my experience, a decision in several cases to carry out abrupt withdrawal has been based on the daily intake when the patient's history is reliable. With co-operative patients, I have had success in withdrawing the drug on an out-patient basis by a program of gradual reduction of dosage by one and a half grains per day. In those cases where the patient is withdrawn in the hospital setting, they are first stabilized on a dosage of their own drug or pentobarbital given every four hours to maintain them comfortably, and then their daily intake is reduced by approximately one and a half grains. Sometimes it is necessary if the patient becomes apprehensive, nervous and weak, to elevate the dose and maintain him at that level for a day or two before carrying on with the withdrawal. Because of the danger of psychiatric disturbances, the patient should be observed at all times by nurses or attendants and physicians trained to recognize early manifestations. Since fully developed barbiturate withdrawal psychoses are not readily reversed, it is better to err on the side of excessively slow reduction than the opposite. In severely addicted individuals, a month or more may be required for complete withdrawal of barbiturates.

Co-Existing Addictions

If barbiturate and opiate addiction co-exist, as is not infrequently the case, then withdrawal of the opiates should be accomplished first, while the patient is stabilized on barbiturates. Curiously, many patients who tolerated a given daily stabilization dose of barbiturates well previously, will exhibit more evidence of barbiturate intoxication after opiates have been withdrawn. In such cases, the stabilization dose may be reduced somewhat before systematic withdrawal is initiated. The use of anti-convulsant medication such as Dilantin and Mysoline has been tried, but their effectiveness is hard to evaluate due to the lack of controls. Isbell has been of the opinion that

their effectiveness is very controversial and feels rather that the important thing to remember is a slow and prolonged withdrawal phase lasting up to 21 days if necessary.

General rehabilitation measures consist of dietary, social, vocational, and recreational procedures. Small doses of insulin before meals often aid the dietary problem although appetite usually returns to normal after the withdrawal period. The general rehabilitation measures are only supportive. Psychological treatment directed toward the patient's personality needs is necessary if any constructive result is to be expected. Group therapy and other specific therapy such as ECT may be necessary when indicated.

After the withdrawal period has been successfully accomplished, a more detailed psychological study of the patient may be made in order to start a psychotherapeutic program aimed at reducing the underlying factors in the addiction and so prevent relapse or at least to reduce its incidence.

When individual therapy is found to be suitable it must usually be planned over a long period of time. Many of the older addicts with fixed patterns will not be as suitable for such therapy as the younger addict in whom the ego strength is relatively well developed and who expresses, or is capable of expressing, overt anxiety and whose goals and strivings show a good contact with reality and an awareness of social and cultural demands.

Complications of Psychotherapy

The problem of psychotherapy is complicated. What the psychotherapist does, says, looks for, finds, misses, emphasizes or ignores, depends to a great extent on the body of concepts concerning behavior which he accepts as valid and relevant to the problem at hand, and these, in turn, determine to a considerable degree the response elicited from the patient. Yet, validation of such concepts by the scientific test of predictive utility, has proved to be a difficult task in all areas of interest to psychiatrists, including that of drug addiction. Thus, it is not surprising that psychiatrists differ widely in their views concerning the psychodynamics of drug addiction and the particular problems which should be explored in formal psychotherapy. Hence man must be seen in his addiction as a whole, and treated as such.

The prognosis in chronic barbiturate addiction must always be guarded. In my experience, those patients with character disorders showed evidence of multiple addiction and did very poorly. In the psychoneurotic group, many had been started on drugs by a physician to relieve their insomnia, and these people showed good motivation with a higher recovery rate with psychotherapeutic help after withdrawal.

Education and Control Are Required

There is no doubt about the need for education and research in this field. Education of doctors and the public towards using fewer hypnotics, as well as research to produce effective but less toxic ones, is indicated so that in the future men plagued with insomnia and anxiety may require fewer pills or chemical comfort but may have at their disposal safer drugs when needed. In education, a philosophy is required which stresses the need to face and understand problems as being better than our present slogans of finding "fast, fast relief" in chemicals.

While there is no doubt that barbiturates are effective and valuable drugs, we must be cognizant of their ever increasing consump-

tion. Many cases (the true numbers as yet unknown) of habituation and addiction, as well as an increasing incidence of accidental over-dosage and suicide should cause us to look at the problem seriously, and we must not fail to consider the needs of the total person who is being prescribed one of these drugs.

To achieve the end of more effective knowledge about control of barbiturates, information currently being gathered by the Narcotic Control Division of the Department of National Health and Welfare, may lead to the conclusion that a more rigid prescription control, as with narcotics, would be to the ultimate advantage of both the patient and the medical profession, even though at first it would be considered a nuisance by both.

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WHAT WE DON'T KNOW ABOUT ALCOHOL PROBLEMS

by HAROLD KALANT, M.D., B.Sc., Ph.D.

Dr. Kalant is Assistant Director of Research (Biological Sciences) of the Addiction Research Foundation of Ontario. This article is slightly revised from the closing lecture given by Dr. Kalant at the summer course on Alcohol Problems sponsored by the Addiction Research Foundation. The first two week course was held in June, 1962 at the University of Toronto.

LOOKING BACK on the summer course on alcohol problems, it appears that there was a rather neat breakdown of the contents of the sessions during the two weeks. The subjects dealt with in the first week were essentially aspects of the interaction between alcohol and the individual, starting off with things like pharmacology and pathology (what alcohol does to the nervous system, to the liver, etc.). Then we looked at what alcohol does to the individual's behavior, as determined by pyschological tests, and then in terms of grosser measures of performance in one's everyday life. We considered problems of individual therapy, the relation of the individual patient to the therapist and so on. All of these things we might include under the general title of the relationship of the individual to alcohol. Then, during the second week, the stress was mainly on the interactions between alcohol and society—such things as the moral and religious aspects of community values and alcohol, the law, education, industry, community resources for treatment, and so on. Many of these were not only extensions of topics from the first week, but raised whole new points of discussion.

Moral Responsibility

For example, in the moral field, Father Ford began the second week with an extremely valuable distinc-

tion between what is considered an individual's moral responsibility for drunkeness, assuming he has a responsible free choice, and the situation presented by mental illness in alcoholism, in which the individual cannot make this choice. And, of course, this distinction has obvious implications for the people most actively engaged in the treatment of alcoholism, referring back in a sense, though not explicitly stated, to the point which Dr. Holmes had raised the previous week about the attitudes and values of the people engaged in therapy. Only by recognizing the validity of this distinction can one eliminate from the therapist's approach the idea of 'reforming' someone, based on an implied censure of his behavior, as opposed to the idea of treatment based on some understanding of the difficulties which the individual encounters. It underlines the difference, in other words, between a punitive and a therapeutic approach. This, of course, also relates to the relationship between the law and those who encounter problems with alcohol—such obvious things as the relative contribution of alcoholics to the total of traffic accidents under the influence of alcohol, crimes committed in relation to alcohol or under the influence of alcohol, the chronic drunkenness offenders who fill the jails and thus pose both a legal and a social problem, and so on. Here, too, we must consider the point which Mr Justice Kelly made about the gradual change in the interpretation of the existing law, and perhaps the point which was raised about the need for specific changes in the laws, to reflect a greater flexibility of approach, a change in emphasis of the law from the punitive to the corrective. This, of course, brings up the question that was raised about the applicability of compulsory therapy, i.e. whether therapy which is given under legal compulsion can be still interpreted as therapy rather than punishment.

Alcohol and Industry

There was discussion on the role of industry in relation to the problems of alcohol, and it was suggested that, in the view of the people in industry, too much has been made of the economic importance of alcoholic absenteeism to industry. Perhaps this is so, but there is a different point to be raised. One doesn't consider a job that takes up perhaps 50 per cent of one's waking hours as just a means of livelihood; it represents a very substantial chunk of one's total environment. Thinking in this line, it's pretty easy to see that the effects of strains and pressures in one's job, the effects of frustrations and irritations and ambitions in one's working hours, may well have some importance in the production of an emotional environment in which alcoholism can thrive. The handling of this work environment at least poses a serious social problem. And, of course, if the economic significance of alcoholism to industry itself is not as great as has been claimed, nevertheless the economic significance to the community of loss of income from the individual's pay packet, and what this means to the family, is still a very real problem.

In relation to community resources the question was raised about the analogy between community action in relation to alcohol problems and the community campaigns for control of things like cancer or tuberculosis or other communicable diseases. Along with this, we considered the very important question of community responsibilities in education from the public health point of view, the prevention of alcoholism particularly in relation to work with teenagers or young people generally. In

a way this was a very good theme to end on, because it carried back almost full cycle to Dr. Jellinek's introductory lecture on the first day, about the symbolism of alcohol —what it is that attracts people, young or old, to begin drinking in the first place, quite independently of the pharmacological or other specific effects of alcohol as a substance.

What We Learned

Well, this makes a very pretty picture on the face of it. Looking back over the program, over some of the things that were discussed, and some of the questions raised, it sounds like a nice, well-rounded picture. We can all pat each other on the back and say, "Yes, we're very broad-minded, we've considered all aspects of the problem, we've traded views", and to some extent this is right. I'm sure the hope is that an outline of a thoroughly comprehensive picture has been given of the relation of alcohol to the individual and to society. The need has been stressed repeatedly for this comprehensive picture, so that each specialist in his own field can do a more effective job in his own right, and can tie his work in more effectively with the work done by people in other specialties for the sake of an overall preventive and therapeutic effect. It is important to consider how this broader picture can be translated into real contacts within the community. For most people who are not directly connected with specialized alcoholism treatment centres, all of what we have been talking about reveals a need to go out and create such

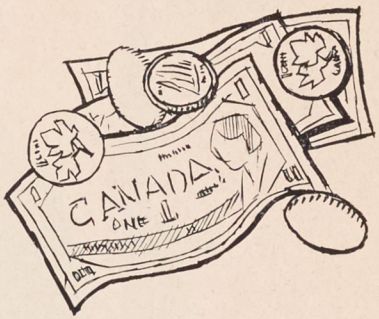
contacts in one's own community, the need at least to do your own 'hard sell' to the other specialists that you have to deal with in various phases of activity in each individual community. It is our hope that the summer course has created some enthusiasm for this job, based both on an appreciation of the scope and size of the task and also on a recognition of the possibilities that have been indicated for more effective contributions.

What We Didn't Learn

Well, as I have said, all this makes a very pretty neat picture; but after reviewing all of the things that we hope have been discussed and learned and evaluated, I'd like to end on a sober note by talking about a few things that haven't been learned or discussed, and perhaps give a slightly more realistic balance to what the course yielded. Some of these unknowns, some of the things that were not touched upon during this course, simply reflect a lack of time. In two weeks, you can't discuss the whole problem of alcohol and expect to give the last word and detail on every possible aspect. The most we can hope to do is give perhaps a better way of looking at the problem, so that you can evaluate in better perspective your own particular relation to it. But many of these unknowns are truly unknowns, because nobody does have the answers; and it's from this latter group that I'd like to draw a few dangling loose ends that you can carry away with you for later consideration.

Role of Economic Factors

One of these loose ends is the role of economic factors. I'm not thinking of economic factors in the sense of political propaganda—we all know, I'm sure, that in the Russian view, in a communist country, there is no problem of alcoholism because everybody's happy; all we have are some reactionary, bourgeois, capitalist backsliders. I'm thinking of the economic factors in a slightly more serious sense; things, for example, like Dr. Seeley's study which raised the question of the role of price of alcohol in relation to alcohol consumption. The gist of



it was that as the real price of alcohol (the fraction of a person's earning power that he had to spend to buy his alcohol) decreased, accordingly the consumption increased, and this appeared to be accompanied by an increase in cirrhosis—the increase in cirrhosis of the liver indicating, we presume, an increase in the frequency of alcoholism in the community. In the panel discussion during the first week, Mr. Popham, Dr. Jellinek and Dr. Jacobsen dealt with patterns of alcohol use in other countries and other cultures. This sort of discussion raises the question of what role poverty in other countries may play in the use of alcohol; for example, some of the Chilean social workers have claimed that poverty and overcrowding are among the principal sources of personal and inter-personal tension which give rise to an increased use of alcohol.

Add to this the fact that alcohol is cheaper than almost anything else the Chilean can drink, and you have what appears to be a very good reason for the very widespread problem of alcoholism in Chilean society.

Increased Prices: Gain vs Loss

This sort of consideration, right or wrong, gives rise to the speculation, "If we decide that price is an important factor, shouldn't we raise the prices and see if we can decrease the consumption of alcohol and decrease the frequency of alcoholism?" Well, this sounds like a good experiment to do. It sounds like a nice sharply defined problem; there's a hypothesis, and a simple way of testing it. But then you begin to wonder, in the light of what both Father Ford and Dr. Jacobsen said, what would happen to the community at large, if you were to take away one of these chemical comforts which so many people depend upon to a greater or lesser extent, for tiding them over the inevitable frictions and frustrations and difficulties that they have? By pricing alcohol out of easy availability to people of modest income, you might benefit the community by decreasing the frequency of alcoholism and cirrhosis. But what of the increase in disgruntlement and irritation and so on, on the part of the population that now uses alcohol without ill effects? How would you compare, how would you assess the relative gain against the relative loss? Who is in a position even to say how he could evaluate these things? Here's a whole question that we have to leave dangling, because until someone has a good fool-proof method of weighing the gain and the loss, and deciding what the balance is, other than one of pure statistics, you would certainly have to think twice before engaging in such a large-scale experiment.

Non-Drinking Alcoholics— A Problem?

Another question I would like to raise is "What happens to the alcoholics who stop drinking?" The idea of the follow-up study was referred to repeatedly, and the concept of substitute pathology was considered in other words, one way or another. I recall something a medical student said to me this year, in discussion after a classroom experiment on alcohol and tranquilizers. He asked "What happens if someone does stop drinking, without too much trouble, and then it turns out that he becomes terribly disturbed emotionally, and becomes much harder to deal with than when he was drunk?" I replied that this was a rather unlikely situation and that usually if a person could stop drinking, hold a job, and so on, it was likely that his emotional disturbance was less severe than in the case of a person who couldn't stop drinking until he got individual psychotherapy. He said, "My father was an alcoholic—he was drunk most of the time, and he was irresponsible as far as his job was concerned, but at least we were happy at home; and then about ten years ago he stopped drinking. He managed to hold a job, and he brings home the pay every week, but he's absolutely impossible to live with." Well, I couldn't contradict him—after all, he knew the situation in the case of his own family, and this raised some serious questions.

We assume that by definition our objective is to treat alcoholism, to stop the excessive and damaging intake of alcohol; and undoubtedly, generally speaking, this is the objective which faces us. But doesn't this have to be qualified? Is it possible that this may not be the situation in some individual cases? For example, do we know enough

about the individual psychiatric features involved to be able to say categorically that there are no cases in which alcoholism may be the lesser of the two evils? Obviously, the only answer to such a question is that we need a great deal more follow-up of what happens to people who stop drinking, and it would be very wrong indeed if one were to leave a course such as this with the idea that the end result could be taken for granted.

Significance of Mixed Addictions

Another question that was hinted at, or discussed lightly during the proceedings, particularly by Dr: Jellinek, was the question of the significance of other addictive or potentially addictive drugs. We know certainly a great deal about pharmacological actions of different types of drugs; we know some of the borderline, some of the overlap, between alcohol, tranquilizers and barbiturates; we know something about how one drug may partially substitute for another, or how one drug may enhance the effect of another. But of course, scientists are not unique in this knowledge—a great many people who use drugs already knew these things by trial and error. You all know that many alcoholics get, later on, to depend upon the combination of alcohol and barbiturates, and you all know about the prominence which has been given recently to the use of "goof balls", which are a combination of stimulant and depressive drugs.

The question comes up, "What is the significance of these mixed addictions?" Do we know for example, how many alcoholics are also dependent in part upon addiction to other drugs, either alternately or together? And do we know whether such mixtures really alter the outlook for treatment? Are we able to say with certainty what the difference is in outlook, in the hope of cure, if a person has mixed addiction, as opposed to a single addiction to alcohol or to one other drug? Do we know what this does to his rate of deterioration, if he does deteriorate? Do we know what the physical and other effects are? Do we know in how many patients we may cure a person of dependence on alcohol, only to find that he transfers his dependence to something which is a little less obvious? This points out the tremendous need for a great deal more information on related fields, to find out that alcoholism is not a problem to be treated in isolation.

Therapy Doesn't Always Work

There's another question I'd like to ask, too. What happens in the cases where therapy doesn't work? We talked about the social factors which can contribute to drinking, the correction of which presumably help prevent or treat alcoholism. We talked about individual psychological and psychiatric factors that may require attention, again for both prevention and treatment. But there remains the fact that a very substantial number of patients, exposed to all the treatments that we consider to be important or relevant, still do not get better.

Well, what does this mean? Does it mean that one is really dealing with a different type of problem? Or does it mean that the therapeutic factors which we have talked about have not been effectively applied? Or does it mean that other unrecognized factors are playing a role that will have to be brought into the picture? Suppose you say that when social factors, group therapy, physical and medical therapy and education don't work, maybe this means simply that the individual psychiatric needs are still greater than we had realized. Well, where does this leave you? Suppose you decide that there is need of a great deal more individual psychiatric

therapy than has so far been available. What happens if you look around and find that your whole community doesn't have enough psychiatrists to go around, as is very likely indeed? Suppose you find that it is frankly impossible to give all of the treatment on an individual basis that your review might suggest was valid. What does this mean, then, in terms of community evaluation of what therapy should yield? Does it mean that you have to start thinking seriously about the possibility that makeshift treatment is better than none? That perhaps you might even have to decide that the damage done by alcoholism, in other words the disruption to the community, to holding a job, to providing the needs of life for the family, and so on, is great enough that you might deliberately have to substitute dependence upon some other drug if an outright cure is not possible? Here again it is a question of values. How do you decide? On what basis do you decide whether it is better to concentrate on stopping all forms of dependence on drugs, and aim for an outright cure, even if it means treating one person out of ten, or one person out of a hundred, rather than give palliative therapy to 99 out of 100? Who would decide on the scale of values? And does this mean some kind of community decision, rather than individual decision?

All of these things, I think are examples of problems that we haven't really been able to deal with here, couldn't possibly deal with here, because this would mean debating moral and other values, as well as talking of information we don't have. And you can't do that in two weeks obviously.

What Must Be Done

What is the importance of these questions, then, in the overall picture that we hope you have ended up with after your two weeks of

lectures and discussions and arguments? The only answer, obviously, that one can come up with in relation to the unanswered questions, is that they point out our tremendous need for a great deal more information, which means a great deal more research.

Research is always a discouraging word, because when you say 'research' people think about a cure for cancer, or a new type of solid fuel rocket to reach the moon, or some new electronic machine, or what-have-you. It's always thought of in terms of laboratories and highly technical investigations that no one who hasn't been brought up in the field can hope to do. This, of course, is not the meaning of research. Research means a series of relatively easily definable steps beginning with an intelligent question, a question which has been formulated on the basis of available knowledge, and has been expressed in the simplest possible component parts; a question which indicates a lack in our knowledge which you hope to fill. Then, the term 'research' implies the availability of methods that can be used to answer the question. So, of course, you phrase your question in terms of the methods you have available, unless you are prepared to go out and develop new methods suitable for the question you would rather ask. And then it means accurate collection of results by these methods, and an unbiased evaluation of the information you've obtained. The whole process can involve an extremely simple set of methods, an extremely simple question, or it can be a very sophisticated question, requiring sophisticated methods. You fit your methods and your questions to the need that you have.

Research—A Challenge

After completing any course such as this, it is gratifying to be able to look at the fruits of one's labour, to admire the pretty picture of all we know. It is my hope in making these final remarks that you may be stimulated to think equally of the things that we don't know. Perhaps in your own activities you may be tempted to examine a few of these questions that you've been asked, and try exploring some of them with the methods that you have available, so that either you might be able to answer some of them, or you might be able to come up with enough information to stir and spur somebody else to answer them. This is always a nice pious hope to express at the end of any course, particularly if you don't have to take responsibility for initiating any of the steps involved. But there is this reason for it, namely that research is regarded to a large extent by the general public as a special function of a few specially trained people, and in the last analysis, it is not. It is a function of any informed intelligent curiosity. So with this hope, and in the knowledge that I won't have to answer any of the points raised, I'll leave this as the parting shot.

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Men are never so likely to settle a question rightly as when they discuss it freely.

—Thomas Babington.

THE CHILDREN OF ALCOHOLICS

by R. W. RAMSAY

Mr R. W. Ramsay, M.A. (Psych.), has spent several summers at The Alcoholism Foundation of Alberta as counsellor. He will be continuing his studies at the University of Alberta towards a doctorate in Psychology.

EXTENDING HELP to children of alcoholics is as important, if not more important than the treatment of the alcoholic himself. Most alcoholics are married, and since the alcoholic's behavior affects more than four people in his immediate social environment, a number of children are bound to be involved. The problem becomes even more acute when it is realized that children of alcoholics, when compared with children of non-alcoholics, have a greater chance of becoming alcoholics themselves. The problem faced by the children of alcoholics is therefore a challenging and necessary part of the treatment picture.

Group therapy for the teen-age children is probably of most value. Not only can the therapist deal with more people in less time than with individual counselling, but the children need to feel support from others of their own age and to be able to compare their problems with each other. The therapist is much older than the children, he is usually not himself the product of an alcoholic home, and he spends most of his time counselling the alcoholic and is consequently identified by the children as being

on the side of the alcoholic. For these reasons, and because in general the teens is a period of conformity, group therapy seems to be more appropriate.

It is felt by the staff that most alcoholics are reticent to involve their children with The Foundation. One of the reasons given is that it is the alcoholic himself that has the problem, and that there is nothing wrong with his children that he cannot himself rectify. Without outside help, the alcoholic is unable to realize that, just as he exposed his family to the trials and hardships of his illness, so he should allow them to share in the rewards of his recovery. Most often the alcoholic has been so absorbed with his own problems for so many years that he cannot see the problems faced by others around him. By the time he seeks treatment his children have withdrawn from him to such an extent that he no longer is aware of the turmoil his children experience. It is not unnatural for parents to object to someone else taking a hand in the upbringing of their children because it seems to imply some inadequacy in the parent in that regard.

The teen-agers who come in to group meetings are afraid, confused, and suffering various degrees of emotional disturbance. Most noticeably they are extremely hostile towards the alcoholic parent. In the security of the group and in the security of the idea that they can express themselves without fear of punishment, they air this hostility in a manner that might well astound and frighten the parents if they were to hear it. The alcoholic father is the first target, then the mother, and finally, the siblings. This reaction however is only an outburst of pent-up emotion which they probably have not been permitted to express before, and soon passes after the catharsis of verbal expression.

During this phase, the children voice the popular misconceptions about alcoholism and reject, for instance, the notion that they have heard about alcoholism being a disease, etc. Because they have been hurt so much, they are rebellious and reluctant to view the subject dispassionately and rationally. This emotion is best brought out in the group situation where it can expend itself harmlessly, otherwise it would come out in other ways detrimental to both the teenager and the family.

After this phase of uninhibited expression has spent itself, the tone of the meetings changes slightly. While there are occasional outbursts of: "I hate him!" there are also questions showing concern over why the alcoholic parent is the way he is. This is the beginning of education about alcoholism, a period which is taken slowly, and at the speed set by the group. The therapist can guide the meetings to some extent so that questions about alcoholism will emerge, but care must be taken not to do this too soon, nor to take an authoritarian or didactic approach. Should this occur the therapist may lose his group; teen-agers are tired of being taught at school and in the home, and require a place where THEIR ideas are valued and listened to. They are also tired of being treated as children, and appreciate the respect shown to them by an adult listening to them with understanding and sympathy. *Their wisdom is surprising when it is allowed expression.*

Some problems seem to be of outstanding importance since they crop up again and again. Number one: the shame and loneliness felt by the child of an alcoholic. He does not bring his friends home because the embarrassing situations long ago stopped all visits. This engenders hostility which cannot easily be expressed and the child

is usually too ashamed and confused to be able to talk to anyone about it. They complain they cannot discuss their parents' alcoholism with their friends because the friends do not understand the situation. They need someone to talk to who is familiar with their particular situation, and the group here is of more value than individual counselling by a therapist.

The second problem includes both parents. The child is often called upon to arbitrate or verify the word of one parent against the other, or to console one parent when the other has left in the heat of an argument. The children are often torn in their loyalty, and find that they are forced into a position which demands more maturity and stability than they possess. For instance, they are often called upon to run the house and to look after the younger children when long absences of one parent oblige the other parent to work. The demands placed on the child to satisfy the parents' often exhorbitent emotional needs, and to run a household at the same time, is asking a lot of anyone, let alone a teen-ager. The reaction of the teen-ager is once again one of hostility—the demands are too great and escape is impossible.

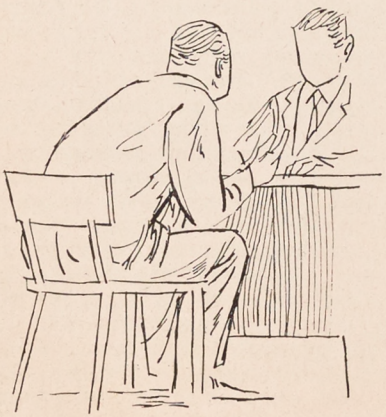
The third problem appears after the hostility has spent itself. The question is raised as to what can be done to help the alcoholic parent. If the parent is still drinking, the question is: "What can I do to help him stop?" If he has already stopped, the question becomes: "How can I keep him sober?" Group discussion of these questions can be of great value as there is a pooling of the children's experiences of parental drunk and sober periods and the factors leading to these different periods.

A fourth problem facing girls in their late teens lies in the tremendous dislike they have developed for anything connected with alcoholic drinking. They are apprehensive, for instance, when their dates drink. Since most teen-age boys drink in this culture when they go out on a date, the girl is severely limited in her choice of partners. She has to choose (1) a date who drinks, (2) a rare teetotaller or (3) go without a date. The boys in the therapy group who are in their late teens have usually experimented with drinking. It is probably a good idea at this time to point out that, as children of alcoholics, they are in greater danger of becoming alcoholics themselves. If they accept the fact, they drink at their own risk.

One of the ways in which a teen-ager tries to protect himself from the hurt of fluctuations of moods in the parent is by means of emotional isolation or insulation. The child withdraws emotionally, builds a wall around himself, and takes the attitude: "I don't care anymore, he can drink himself to death and it won't concern me." This is a defence mechanism which is not conducive to good mental health and happy emotional relations with others. However it should be allowed to develop and be encouraged. A home in which one or both parents is drinking can only damage the child emotionally if he remains vitally involved. It is safer to withdraw emotionally than to go on being hurt. The wall of indifference that the teen-ager builds around himself is a shaky structure, and is built after the personality is reasonably well formed. Being shaky, the wall can easily be broken down when it is no longer needed. A defence such as this does not seem to be a handicap to any extent in interpersonal relations outside the home. A suggestion that has been advocated, that the child try to see the alcoholic parent as two people, one sober and one drunk, does not seem to work well. The

children see the alcoholic parent as one person, whole and integrated, and although they say there is a great difference between the drunk and sober person, they cannot disassociate to the extent of accepting the sober and rejecting the drunk when the situation demands. The drunk is too upsetting and too unpredictable to allow them to do other than reject completely. It is only after a period of sobriety that the parents will once more find acceptance from their children.

Therapy with children of alcoholics is a worthwhile and fascinating field which only recently has come into prominence. Alateen Groups along the lines of AA are becoming popular, and two publications, 'Youth and the Alcoholic Parent,' and 'My Mother is an Alcoholic,' may be found useful by anyone starting out in this field. With the knowledge of the number of people affected by one alcoholic, and the hurt caused by these people, one wonders why more effort is not directed towards helping the children. They have their lives ahead of them, and are trying to overcome the handicaps visited upon them by their parents' illness.



FOUNDATION STUDIES ETHNIC PROBLEMS

FIVE STAFF MEMBERS of The Alcoholism Foundation of Alberta participated in a three-day study of ethnic problems in a special seminar at the University of Alberta, June 13th to 15th, 1963.

Entitled 'Insights into Cultural Differences', the study centered around a series of lectures by Dr. Benjamin Schlesinger, of the University of Toronto School of Social Work. Several excellent topical films by the National Film Board were also used in the presentations.

Sponsored by the Edmonton Welfare Council in co-operation with the Canadian Citizenship Branch, the seminar's forty-five registrants were widely representative of various social work, health, welfare and educational organizations.

A significant contribution was made to the seminar by two of the attending Foundation personnel. They were active in the original planning and publicizing of it, and later, in the editing, collating and compiling of the total seminar material into brochure form for general distribution to university schools of social work, welfare agencies and other organizations concerned with ethnic problems throughout Canada and the United States.

Central objective of the seminar was a searching and objective examination of the ethnic and cultural differences underlying the often profound and painful problems encountered by new Canadians in the course of the process of integration into the Canadian way of life.

Daily morning and afternoon group discussions of the various points made in Dr. Schlesinger's

lectures were free, provocative and enlightening. The most valuable result of these sessions was the emergence of the general awareness that an understanding of both the cultural backgrounds of the various ethnic groups making up Canada's population, as well as a clearer concept of our own cultural and social values, is essential to the creation of the atmosphere needed to ease and facilitate the transition of the immigrant from his old social milieu into the Canadian pattern of living.

The whole problem of the social and economic integration of new Canadians hinges on two basic considerations:

1. The needs of the immigrant
2. The well-being of the country

Key factors in the approach to this problem are communications and understanding. Language, employment, religion, arts, crafts, dress and entertainments are important elements in the former, and knowledge of the various ethnic backgrounds in the latter. Attitudes toward law and family life are also important elements in the integration of newcomers to the country.

The greater the cultural and ethnic differences between the immigrant's old way of life and ours, the more difficult will be the integration process. For many newcomers, the 'ghetto' type of foreign quarter in our larger urban areas was recognized as fulfilling a real need in this sense. It provides a familiar social community, a place of acceptance, approval and understanding — a bridge between the culture of the newcomers' original homeland and a strange new world.

One important aspect of ethnic and cultural differences involves the use of and attitude towards alcoholic beverages among various nationalities. It was noted that, insofar as alcohol is sometimes abused in the individual's attempt to escape failure, frustration and social and economic barriers, an understanding of both alcohol and our diverse society is important.

Edmonton's population is an especially significant mixture of ethnic variations. A comparison of the 1951 and 1961 census figures compiled by the Dominion

Bureau of Statistics shows a significant increase in the admixture of European and other ethnic groups to those originating in the British Isles.

'Insights into Cultural Differences' was a valuable and significant experience for all those participating. Its long-range implications will no doubt indicate the need to continue and expand such studies in the future. In this regard, there emerges the obvious link between adult education and the education of children in our public and high schools towards greater understanding, acceptance and appreciation of the problems and contributions of their fellow Canadians from other lands.

Typical of many of Canada's larger and growing urban centres, Edmonton presents a richly variegated ethnic montage. In the course of walking three or four blocks on any one of Edmonton's busy downtown thoroughfares, one is quite likely to hear the several Slav, German, Nordic, Latin and Jewish languages spoken. The following table gives a breakdown of fifteen ethnic elements in Edmonton's population and indicates changes in their proportion to the total, in terms of percentages. In actual fact, it is estimated that the City's present population includes about twenty different nationalities.

TABLE 1

ETHNIC DISTRIBUTION IN GREATER EDMONTON*

	1951	1961	Number of people 1961
British Isles	56.2%	45.8%	129,977
Ukraine	10.9%	11.3%	32,526
Germany	7.4%	12.3%	34,385
France or French Canada	6.0%	6.6%	17,246
Scandinavia	5.3%	5.3%	14,526
Poland	3.4%	3.8%	11,197
The Netherlands	2.2%	4.1%	9,953
Italy	.4%	1.4%	4,425
Austria	-	-	4,537
Other Europe	2.9%	5.2%	
Russia	1.1%	.8%	2,276
Asia	.7%	.9%	2,747
Jewish	.9%	.6%	1,767
Negro	-	-	491
Other	2.6%	1.9%	3,563

*Source: Dominion Bureau of Statistics—1951 and 1961 Census

All this implies a rich and versatile cultural heritage—along with a challenging variety of social, economic and personal problems born of geographic and cultural change, disrupted communications between the individual and the new society, loneliness, frustration and the often profoundly altered values confronting the newcomer to Canada.

—Editor

REVOLUTION
IN THE MUNICIPAL COURTS

by HOWARD M. BUBERT, Jr.

A legal researcher looks at present approaches to a great social, health and legal problem—and now makes some interesting and practical suggestions.

TODAY, the average municipal court judge finds himself in the midst of a revolution in regard to one large segment of his case load. This revolution involves the legal, judicial and penal handling of the chronic drunkenness offender.

Several decades ago no particular problem was presented by the defendant who was repeatedly arrested for public intoxication or for minor offenses closely related to or involving excessive use of alcohol. These people were deemed outside the pale of the decent, law-abiding citizenry. They were looked upon as willful reprobates and sinners who had purposely ceased to make any effort to conform to society's mores. The law provided penalties for such flagrant conduct, and with a clear conscience and a sense of righteous indignation a judge could impose the full penalty of that law on the chronic drunkenness offender, thereby not only teaching the drunk a lesson but also protecting the morals of virtuous, orderly citizens. Presumably, this simple, straight-forward approach tended to curb a corrupting spectacle and influence.

However, in the intervening years the social sciences, medical science and the art of psychiatry have reared their ugly heads and have brought with them better understanding and knowledge of the phenomenon of the skid row bum and the chronic drunkenness offender. Such persons are no longer considered immoral sinners and mere willful flaunters of society's rules. Instead, it is realized that they are, for the most part, sick and are victims of a complex social system with which they are, perhaps, unequipped to cope. At the same time the judiciary, the police and the penal authorities have come to realize from experience that the presumed objectives of the whole paraphernalia of the criminal law and procedure are not being achieved. The basic philosophy underlying the criminal sanctions and incarcerations of the chronic drunkenness offender are neither acting as deterrents nor as examples to others, nor is rehabilitation being achieved. In analagous terms, putting a diabetic in jail will not deter him from having diabetes, will not by example deter others from contracting diabetes and will not 'rehabilitate' the individual having diabetes. Finally, if these offenders are indeed sick in a physical or social way, or both, the philosophy of 'an eye for an eye' and of punishing in order to enforce payment of a debt to society is completely unsound. Instead, what we are doing is punishing admittedly sick persons for the 'offense' of manifesting the very symptoms of their illness.

The people who have been studying alcohol problems can describe the chronic drunkenness offender with some accuracy and completeness and can tell us that the old concepts are largely erroneous and unavailing; but they cannot as yet tell us what new and better methods we should use to replace the old. There are almost as many suggestions and 'new

approaches' as there are people working with the problem.

This, then, is the revolution in which the average municipal court judge finds himself caught. He knows he is faced with a pressing problem and that he must deal with it in a completely ineffectual way. There is no presently available medical and/or scientific 'solution'. His hands are tied; and, in addition, state and local lawmakers and the great majority of the public are uninterested in helping him solve the problem even to the limited extent that this is presently possible. If the public and the legislatures would become interested enough to act, and if the medical profession, the psychologists and the social scientists could tell the legal profession what to do with the chronic drunkenness offender, then there would be relatively little difficulty in drafting statutes and tailoring procedures to implement these suggestions and, at the same time, safeguard constitutional guarantees.

Present Approaches to the Problem and Their Weaknesses

Although the chronic drunkenness offender is by no means limited to cities and heavily populated suburban areas, the problem is, as might be expected, more acute in such places. And it is in these relatively small and widely separated geographical and political units or areas that the greatest pressure is exerted to do something to alter the present senseless and wasteful methods.

There has been little comprehensive, overall planning. Instead, each community that has done anything at all has usually picked out—partly by choice, partly by chance and partly by expediency—one or two therapeutic type facilities, services or techniques to the virtual exclusion of all else. As a result, we find that City A may operate a jail rehabilitation farm, City B may have a counselling service and an out-patient clinic, and City C may champion half-way houses. What is not done is to provide a fully integrated and graduated range of facilities in any one community nor is there any real attempt made to separate the chronic drunkenness offender group into different, component parts.

It would seem natural to assume —and the evidence indicates that there is some validity in this assumption—that at least some few chronic drunkenness offenders need only be placed on probation and can benefit from some sort of vigorous out-patient counseling service such as those offered by an active and properly staffed probation department or an out-patient clinic. It would also seem not illogical that some offenders need more support than this and so should be placed in a half-way house setting. Finally, many will need the long, complete break with the past that only the camp type facility can provide. However, once their stay is over, they should probably not be released outright, but should be returned to the community by gradual steps with the first one quite possibly being the half-way house.

The Practicalities of the Judge's Situation . . . Some Suggestions

In the present state of law, knowledge and public opinion, these then are the problems that the municipal court judge is faced with in attempting to cope with his chronic drunkenness offender case load. More important, these are some of the major and very basic obstacles to an immediate solution. However, much is being accomplished; and public opinion is being slowly altered. Provincial attitudes among therapy personnel are also changing; thanks, in large part, to

the dissemination of ideas through magazines such as this and associations such as the National Association of Municipal Judges.

It would seem that, from a practical standpoint, the municipal court judge could best deal with the chronic drunkenness offender case load in his court by (1) realizing that there is at present no easy solution, by (2) realizing that, although this may not be properly a criminal problem, it will remain so until public opinion is sufficiently aroused to cause the legislature to change the criminal laws regarding public intoxication, by (3) attempting to learn something about the chronic drunkenness offender, which can be accomplished by reading some fifteen to twenty basic articles on the subject, many of which have appeared in the Quarterly Journal of Studies on Alcohol, by (4 keeping an open mind as to the various allegedly successful 'treatment and rehabilitation programs' currently in existence, by (5) attempting to inform himself of the various types of programs and facilities currently in use, by (6) evaluating them with a critical and educated eye, by (7) supporting local objective and unemotional groups of knowledgeable citizens and members of other professions who are attempting to formulate reasonable overall plans for attacking this problem in the local community, by (8) steering clear of the natural inclination to make hasty and ill-considered piecemeal changes in the laws and statutes, and by (9) taking the lead in the community in attempting to bring together the penal and police authorities and other interested groups in an effort to harmonize and mold community opinion toward handling the local chronic drunkenness offender problem in a more humane and efficient manner.

Comprehensive, State-Wide Planning in Maryland and the N.A.M.J.

One specific, hopeful development is beginning to take shape in Maryland which has been extremely tardy in facing up to the chronic drunkenness offender problem. There, slowly, an overall State-wide approach to the problem is beginning to emerge. Present planning calls for attempts to break down the chronic drunkenness offender group into more easily understood and more readily handled segments, rather than for treating this entire

group as one homogeneous mass, some of whom are presumably motivated and some of whom are not.

Finally, it would seem that the N.A.M.J. could well provide a central national clearing house or repository for objective, factual (not emotional) information on the various current programs and methods for treating and handling the chronic drunkenness offender. Since these programs are most often conducted as integral parts of, or close adjuncts to, municipal courts, it would seem that the Association would be in an ideal position to furnish this extremely useful service which could provide immeasurable aid to localities which desire to inaugurate more humane and efficient methods for handling the chronic police case inebriate. It could also help presently existing facilities to improve their current programs.

Howard M. Bubert, Jr., of Baltimore, is Director of the Maryland Commission on Alcoholism. He holds an AB degree from Johns Hopkins University and an LLB from the University of Maryland and is a member of the Maryland and American Bar Associations. He recently conducted a research project on the legal aspects of alcoholism in Maryland courts.

Reprinted with the kind permission of the Author and the National Association of Municipal Judges. This article originally appeared in 'The Municipal Court Review', November, 1962, edition.

U. OF A. MEDICAL STUDENTS IN FOUNDATION ALCOHOL RESEARCH

by D. M. BELL, M.D.

FAVOURABLE experience with summer employment of University of Alberta medical students in past years has encouraged the initiation of a broader program, and this summer The Foundation extended honorariums to six students in alcohol and alcoholism research. Grants for summer work in the research department were also made to two students majoring in education and psychology.

Mr. K. Kolotyluk and Mr. C. Harley, working under the guidance of Dr. J. D. Taylor, of the Department of Laboratory Medicine at the Misericordia Hospital, continued studies involving the physiological and psychological effects of alcohol ingested in combination with stimulant and depressant drugs. This project was facilitated by the assistance and co-operation of Chief Constable M. F. E. Anthony, members of the Edmonton City Police Department and the faculties of Pharmacology and Psychology of the University of Alberta.

Miss Barbara Robinson, under the direction of Dr. D. Campbell, Chief Biochemist at the University of Alberta Hospital, pursued biochemi-

cal studies in certain aspects of delirium tremens.

Mr. D. James undertook an extensive review of the literature concerning liver cirrhosis, and examined University Hospital records in an attempt to determine certain factors in the development, diagnosis and treatment of Laennec's cirrhosis. Mr. W. Braul conducted similar studies at the Col. Belcher and General Hospitals in Calgary.

Mr. M. Weisler, University of Alberta psychology graduate and presently in medicine at University of Western Ontario, worked on problems of communication, particularly in audio-visual and publications media.

Mr. Paul Peel conducted a study related to drinking among teenagers, and Mr. W. D. Eccleston reported his observations on drinking behavior at a nearby summer resort.

To date, these have been entirely satisfactory ventures. The students have collected valuable data and acquired some knowledge of research techniques. They have also gained considerable insight into the complex field of alcohol and alcoholism.

Moreover, these summer student projects have also served to enlarge and intensify the developing interest and co-operation of the various university faculties, the hospitals,

and other organizations, in the field of alcoholism treatment, research and education.

The Foundation is particularly interested in graduate and undergraduate students in medicine, psychology, sociology and education. Although this summer student program is only one facet of The Foundation's various research activities, it is very worthwhile, and it is hoped that it may be continued in future years.

Dr. David M. Bell, Medical Director, has been associated with The Alcoholism Foundation of Alberta since its inception. Until the recent arrival of Dr. Cyril C. O'Brien, he was also Acting Director of Research.

Behind an able man there are always other able men.

—Chinese Proverb.

STOP NOW - - STAY LATER

by GORDON N. HOBSON

A former journalist, Gordon N. Hobson, B.A., M.A. (Psych.), reveals both his writing skill and his psychological insights in this incisive commentary on the paradoxes of human behaviour. Mr. Hobson has counselled at The Alcoholism Foundation for the past four years, and his return to the University of Alberta this fall will enable him to complete work on his Ph.D.

THE HUMAN RACE is encouraged to believe that it is superior to all other living things. This is brainwashing of the first order. Even a dumb white rat knows better than to persist in some habit—the known consequences of which are destructive. Man's insufferable conceit, however, enables him to ignore the writings on the many walls and, higher cortical development notwithstanding, to sink in the ooze of his own destrudo.

Fortunately, man does not have to answer to the dumb white rat. How, though, does he speak to his own progeny?

The general situation is something like this:

The probable consequences of excessive habits (smoking, eating, drinking, etc.) are well documented. In general, habitual excesses lead to a short and miserable life, statistically predictable to be the fate of X persons out of 100 who overindulge. Cancer, heart diseases, mental illnesses—while not guaranteed—become more likely.

Discovery of suspected causal factors inevitably leads to preventative campaigns, presented to the public under the guise of education. The 'truth' is placed before the people. The consequences of failure to change given habits are not left in doubt. The theme: STOP NOW—STAY LATER

While varied, public reaction as judged by behavioural changes gives the scientific researcher the impression that he is not wanted. Even his best friends tell him so. For instance: Withersbottom is buttoned to the TV. As the relationship between smoking and cancer is discussed, he contemptuously sucks smoke deep into his pock-marked lungs. He's tense, all right. He's agitated, sure! Why, he demands to know, should his viewing of Six-Gun McGinty be thus interrupted! So he dies young! So what? He can't break the habit anyway.

For instance: Bender-boy Woodcock is just opening his seventh fifth of the fourth day. Although he knew the consequences of this

one would reduce him to a social blob, this knowledge did not stop him. Of course, and as he tells his wife and his boss, he could break the habit if he really wanted to . . .

Little wonder that our scientific researcher is puzzled. Something is obviously wrong. He, in no small measure, earns his living trying to motivate man to change deleterious habits and shoot for optimum health. Man, meanwhile, uses his earnings to resist such temptation. It is this paradox that brings into question man's self-styled superiority over other animals. No laboratory animal willingly becomes habituated to substances that might be termed destructive.

By choice, for instance, the cat in a normal environment will not touch alcohol and will never yearn for nicotine. Such maladaptive habits, like all habits, are LEARNED by man. They are in some perverted way a function of that which is held to differentiate him from the lower animals — greater cortical development.

From the white rat's point of view man-animal must be seen as demented. He claims to know how habits are formed, how they are strengthened, weakened and extinguished. Indeed, the psychologist in the first place used the rat to establish empirically his first principles. Little wonder that the rodent has difficulty figuring out why superior man-animal cannot easily apply these principles to his own behaviour. Why does man-animal obliviously carry on when the consequences of not making changes in certain habits are psychically and/or physically destructive? Man's face-saving reply to the rodent is that 'human' behaviour is too complex for the rat to understand. This may squelch the rat—who will return to the simple pleasures of bar-pressing—but it begs the question. Why do certain habits (thinking mainly of those we desire to be rid of) appear to defy change, appear to defy the apparent sincere and honest intention of the individual faced with calamity unless he succeeds?

While open to the criticism of simple-mindedness, a probable answer seems to lie in the fact that the concept of habit is generally misunderstood. As Osgood[1] states, the term is used frequently and loosely in both lay and psychological discourse. For instance, father has the bad habit of drinking, mother the bad habit of smoking and junior the bad habit of swearing. Such idiomatic usage of the term may well be why so many fall into the trap of perceiving a habit as a singular behavioural incident, instead of as a behavioural complex.

From an historical viewpoint, habit first came into prominence in the writings of William James[2], 1890. The major problem he found was in defining the term. James was eventually led to the fundamental properties of matter for his answer: "The laws of nature are nothing but the immutable habits

FOUNDATION TO MARK TENTH ANNIVERSARY

The Executive and Board of Directors of The Alcoholism Foundation of Alberta are now taking steps to organize a formal exercise to mark the 10th Anniversary of The Foundation's public service in this Province. Although the date has not been set as the issue went to press, the observance will probably be held late this fall at the Northern Alberta Jubilee Auditorium.

which the different elementary sorts of matter follow in their actions upon each other". Such theorizing may serve to indicate the kind of precedent that has long existed for regarding habitual processes as being far from elementary. It may be of further interest to note that James' theory, which to a greater or lesser extent pervades contemporary thinking, was sired under the influence of Darwinism with its emphasis upon the **adaptive character of behaviour.** "It is habit alone", said James, "that keeps us all within the bounds of ordinance". Ironic, is it not, that the habits with which the therapist finds himself concerned are primarily maladaptive.

A tentative conclusion, then, is that difficulty experienced in extinction of certain habits is directly related to knowledge of the underlying processes. In the case of smoking, (in principle all habit patterns can similarly be examined, to stop smoking seems to be more obviously universal than others) when our naive subject decides to break the habit, he does what to him seems to be the logical thing: throws away the weeds and tells all and sundry that he no longer has the habit of smoking. He sincerely believes this is all there is to it. When a few days later he is caught sneaking the odd lungful behind the filing cabinet, everyone, including himself, expresses puzzlement. He more than likely will be heard to say: "Well, I could stop if I really wanted to—in any case, half those guys doing cancer research don't agree with the other half, so what".

Would things have been any different had our subject been of the persuasion that, rather than a singular behavioural act, a given habit is really a constellation of many behavioural acts? Experience inclines belief in this. Take smoking once again, this time as a **pattern of complex behaviour.** Our subject is observed consistently to 'use' a cigarette under the following conditions: as he prepares to shave, after each meal (and with every additional cup of coffee!), when he is depressed for a variety of reasons, or when he is similarly elated; when he finds himself in any anxiety-creating situation—such as being interviewed for a job—such as waiting to have a tooth pulled, or such as preparing for an examination. While the list could be extended, the nature of the habit pattern may now be evident. A singular response, in this case smoking a cigarette—is connected with an astounding number of stimuli—any one of which (or any combination) may be considered capable of eliciting the smoking response. In light of this, is it any wonder that **just** throwing away the cigarette fails in a majority of cases to change the habit for any length of time? Too many unknown stimuli lie in wait to elicit the response which leads to the expression: "I've no idea why I started again—sure didn't intend to!"

The reader might be reminded at this point that the smoking habit complex is being used merely to illustrate dynamics which, it is believed, are equally applicable to other maladaptive habit patterns, e.g., alcoholism. In any similar case, such 'bad' habit patterns are considered to be a complex of indiscriminative behavioural responses.

What about practical application? In its simplest form, (a) a habit pattern has first to be identified, e.g., the stimuli with which the response appears to be connected, (b) within whatever theoretical framework, attempts are made to extinguish these connections. The subject, now aware of the 'hidden persuaders' can more hopefully do battle.

Does it work? While rigorous experimental design was not invoked, no great discomfort is experienced in suggesting that it does—at least in regard to the particular habit pattern examined, that of alcoholism. From the beginning of treatment, both therapist and client are able to communicate about observable behavioural phenomena in a language that can be understood. Whether or not an Id (if it exists) is at the basis of the trouble is deemed irrelevant. The client is immediately — and quite unabashedly directively— encouraged to explore his sundry environment of TODAY to discover, as well as he is able, what stimuli elicit TODAY'S response of drinking. The major therapeutic problem is thus seen to be that of establishing, through the client's 'eyes', the composition of the habit pattern of drinking. To the successful, the chant of I-don't-know-why-I-did-it-but-I-did, becomes I-know-damn-well-why-I-did-it-now-I-don't.

It might now well be asked how white rats and higher cortical functioning justified their place in this dissertation. The white rat, and others like him, are purely hedonistic. They learn remarkably quickly and well to avoid behaviour which leads to 'hurtful' consequences. Man, on the other hand, finds that his splendidly superior cortex makes him feel somewhat guilty about his lack of knowledge relative to its function. To atone for his guilt feelings, he utilizes these higher mental processes to create the bloodiest masochistic habit patterns. He neither wishes to stop now nor go earlier.

1. Method & Theory in Experimental Psychology—C. E. Osgood, 1962
2. Principles of Psychology, W. James, 1890

FOUNDATION COUNSELLOR ATTENDS INTERNATIONAL CONGRESS OF PSYCHOLOGY

Mr. Gordon N. Hobson, Clinic Counsellor at The Alcoholism Foundation, was delegated by the University of Alberta to attend the 17th International Congress of Psychology in Washington, D.C., August 20 - 26. Organized by the American Psychological Association for the International Union of Scientific Psychology, the Congress was attended by more than 2,000 participants from all over the world. Its chief purpose was the exchange of ideas and a special emphasis on the need for research into such areas as human motivation, behaviour genetics, biochemical correlates of behaviour, etc. developed.

If what shone afar so grand,
Turn to nothing in thy hand,
On again! the virtue lies
In the struggle, not the prize.

—Lord Houghton

ARE ALCOHOLICS SUICIDAL?

AMONG THE MANY hypotheses as to the causes or precipitating factors of suicide, alcohol occupies a prominent place. Many investigators in Europe and North America have attempted to find a connection between drinking, intoxication, alcoholism and suicide, and a large body of knowledge does suggest that many alcoholics commit or attempt suicide; that many suicides are alcoholics; and that many attempts, whether successful or not, are made while the person is intoxicated.

In the United States, E. Robins and his co-workers (St. Louis, Mo.) found that among 134 successful suicides 31 were alcoholics. In Scotland, I. R. C. Batchelor found that 21 per cent of 200 consecutive cases of attempted suicide had a history of excessive drinking. In England, N. Kessel and G. Grossman followed up 218 alcoholics (46 of them women) discharged from London hospitals; 13—all men—committed suicide within 4 years. P. Epps found 24 "chronic alcoholics" among 100 women charged with attempted suicide in the same city.

Two studies from Scandinavia suggest a relationship between alcohol consumption rates and suicide. In Sweden, G. Dahlberg observed that the male rate of suicide dropped in World War I but not in World War II. He suggested the explanation that during World War I liquor was strictly rationed while in the last war there was little restriction on drinking. In a comparison of annual suicide rates in Finland with the per capita consumption of alcohol, V. Verkko showed a direct relation between the two. Some studies reveal the frequency of suicidal attempts under intoxication. E. Ringel and H. Rotter (Austria) report that 15 per cent of 506 suicide attempts in 1955 were made while the person was drunk. E. Stengel and others (London) recorded that 19 per cent of 73 men and 14 per cent of 44 women who committed suicide had been drinking to excess before the incident. F. J. Ayd reported that in a 5-year period the blood alcohol level was found to be over 0.05 per cent in 35 per cent of 617 suicides in Maryland.

A recent study by I. P. James, D. N. Scott-Orr and D. H. Curnow (Australia), of 50 patients brought to a Perth hospital following an unsuccessful suicide attempt, indicates that drinking may play an important part in such attempts far more frequently than might be judged if the patients' own account is accepted without question. An assessment of the patients' physical and mental state, details of the suicide attempt and samples of blood were taken on admission. At a later date additional information was obtained from the patients, their relatives and other sources. The 16 men and 34 women ranged in age from 15 to 59 years and their blood alcohol levels from 0 to 0.23 per cent, except a 69-year-old man with a long history of alcoholism whose blood alcohol level was 0.39 per cent. Eleven of the men and 20 of the women had blood alcohols above 0.05 per cent; 14 had levels above 0.15 per cent. Taking all the evidence into account, at least 12 were drunk at the time of the attempt and 12 more were

under the influence of alcohol to an extent that might impair judgment. Twenty-eight of the patients had attempted suicide by taking barbiturates, the remainder by taking other poisons, or by cutting or gunshot. Twenty-nine of the attempts were evaluated as of a minor nature, constituting little real danger to life, but 17 resulted in definite danger to life and 4 in a grave threat to life without emergency medical treatment. No significant relation appeared between severity of the act and blood alcohol levels. All had attempted suicide in the face of some domestic crisis or situational disturbance—in 4 cases of a very minor nature.

The great majority of the patients showed evidence of psychiatric disorder. Eleven were classified as psychotic at the time of the act, 28 had a history of personality disorder. Six men and 1 woman had a history of alcoholism; 2 were epileptics; and 4 of the women (3 unmarried) were pregnant.

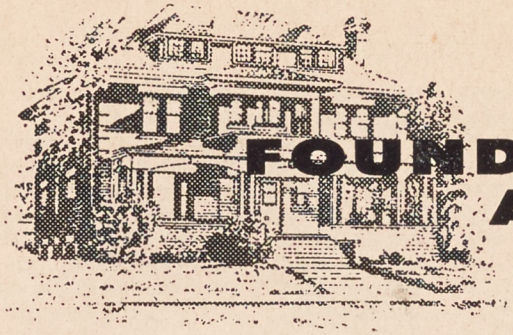
Each patient was asked if he had been drinking at the time of the attempt. Twelve of those with blood alcohol levels of 0.05 per cent or over denied having taken any alcohol at all, and 6 others who admitted that they had been drinking gave estimates of the quantity far below what would produce the demonstrated level. When confronted with the laboratory findings most of those with high blood alcohol levels admitted the truth. Those who had denied or underestimated their drinking apparently did so out of embarrassment or shame, or fear that such an admission might antagonize the hospital staff.

The authors conclude that alcohol is one important factor in suicide. "The temporary effect of alcohol intoxication on a person's judgment and attitude to life may be profound. Alcohol may induce depression or lability . . . hostile feelings or self-pity. It may decrease the inhibitions and self-preservatory tendencies which guard the melancholic from suicide or intensify the feelings of inadequacy and personal failure of the neurotic. A proportion of the suicidal acts carried out under the influence of alcohol are impulsive, unpredictable and explicable only in terms of the intoxication state."

A psychoanalytic conception of alcoholism as a form af gradual suicide had been elaborated by Karl A. Menninger in his book, **Man Against Himself.** But this idea is older than psychoanalysis. C. Wilson (Edinburgh) wrote in 1855 of the excessive drinker's suicidal attempt: "It is by a kind of double suicide that the last act is perpetrated. . . . The more gradual self-destruction is crowned by the rapid catastrophe which kills by violence." Thus it appears that therapists and other caretakers who have contact with alcoholics should be ever alert to detect suicidal trends in this class of patients and be prepared to take appropriate preventive measures.

Cause and effect are two sides of one fact.

—R. W. Emerson.



FOUNDATION ACTIVITIES

PROMINENT SCIENTIST JOINS A.F.A. STAFF

Professor Cyril Cornelius O'Brien, Ph.D. (Psych.), Mus.D., a Canadian by birth (Halifax, N.S.) and recently Professor of Education at Marquette University, Milwaukee, Wisconsin, has joined the staff of The Alcoholism Foundation of Alberta as Director of Research. Dr. O'Brien has distinguished himself in a wide field of scientific research centering around psychological and educational concerns, and has also earned a doctorate degree in music. His biography is listed in a large number of scientific and educational American journals.

A.F.A. DIRECTOR KEYNOTES MIDWEST INSTITUTE

J. George Strachan, Executive Director of The Alcoholism Foundation of Alberta, delivered the keynote address to the Midwest Institute on Alcohol Studies, June 17-20, at Western Michigan University, Kalamazoo. Entitled 'THE NATURE AND EXTENT OF PROBLEMS RELATED TO ALCOHOL', the talk presented a searching examination of the socio-cultural and medical involvements of alcohol and, in conclusion, called for a challenging re-examination of motivation, resources and attitudes among both professional and lay organizations concerned with solutions to alcohol problems.

FOUNDATION STAFF AT RUTGERS

Foundation staff members Miss Effie Cuthbertson and Mr. James McInerney attended the July, 1963, session of the internationally recognized Summer School of Alcohol Studies at Rutgers University, New Brunswick, New Jersey. Particularly valuable to the Alberta program were lectures and seminars on both youth and adult alcohol education processes. A visit to AA General Service Offices afforded a meeting with AA co-founder, Bill W., who expressed his appreciation of the work of The Alcoholism Foundation of Alberta and sent greetings to the Executive Director and staff.

NEW TELEPHONE NUMBER

Please note The Foundation's new Edmonton telephone number
Clinic and Administration

PABX -- 424-1141

OTHER FOUNDATION SERVICES

- **ADVISORY SERVICES:**
  Professional advice and assistance on the problems of alcoholism

- **AUDIO-VISUAL AIDS:**
  Films, tapes, records and displays are available on loan

- **CONFERENCES and SEMINARS:**
  To create a better understanding of the problems of alcoholism and methods of dealing with those problems

- **INDUSTRIAL WORKSHOPS:**
  For the education of management, supervisory staffs and general employees in Alberta industry

- **ORIENTATION PROGRAMS:**
  For nurses, doctors, internes, penal officials, personnel managers, social workers, clergymen, teachers and other groups

- **PUBLICATIONS:**
  Progress, Digest on Alcohol Studies and original brochures and pamphlets

- **REFERENCE LIBRARY:**
  Books, pamphlets and publications by authorities in the field of alcoholism

- **SPEAKERS' BUREAU:**
  For professional, industrial, church, social, school, civic and other groups requesting information

The illustrations in Progress are by Harry Heine

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